RFA #18439 / Grants Gateway # DOH01-PICHC-2020

New York State Department of Health

Center for Community Health/Division of Family Health/ Bureau of Women, Infant and Adolescent Health

Request for Applications

Perinatal and Infant Community Health Collaboratives

KEY DATES:

Release Date: 7/28/2021
Applicant Webinar: 8/18/2021 at 2:00 PM, Eastern Standard Time
Questions Due: 8/23/2021
Questions, Answers, and Updates Posted (on or about): 9/6/2021

Applications Due: 9/27/2021 by 4:00 pm, Eastern Standard Time

NYSDOH Contact Name & Address: Nick Foster
Bureau of Women, Infant and Adolescent Health
New York State Department of Health
Room 859, ESP Corning Tower
Albany, NY 12237
PICHCRFA@health.ny.gov

I. Introduction

The New York State Department of Health (NYSDOH) is issuing this Request for Applications (RFA) to announce the availability of approximately $14 million annually to support implementation of the Perinatal and Infant Community Health Collaboratives (PICHC) initiative. Funds will be awarded to approximately 25 programs throughout New York State (NYS) to support the development, implementation and coordination of collaborative community-based strategies to improve perinatal and infant health outcomes and eliminate racial, ethnic, and economic disparities in those outcomes. Funded programs will work to improve specific perinatal and infant health outcomes including preterm birth, low birth weight, infant mortality, and maternal mortality. The anticipated funding period is July 1, 2022 through June 30, 2027.

The goal of the PICHC initiative is to improve perinatal and infant health outcomes and eliminate racial, ethnic, and economic disparities in those outcomes. The NYSDOH is committing public health resources to communities with the highest need where impact will be greatest. Funded PICHC programs will implement collaborative community-based strategies to improve the health and well-being of individuals of reproductive age (15-44 years old) and their families with a focus on individuals in the prenatal, postpartum, and interconception periods.

PICHC programs will implement individual-level strategies to address perinatal and infant health behaviors, and community-level strategies using a collective impact approach, to address the social determinants which impact health outcomes. The core individual-level strategy is the use of community health workers (CHWs) to outreach and provide supports to high-need, low-income, and/or Medicaid-eligible individuals of reproductive age (15-44 years old) most vulnerable to, or with a previous history of, adverse birth outcomes (the priority population). Community-level strategies involve collaboration with diverse community partners, including community residents, to mobilize community action to address the social determinants impacting perinatal and infant health outcomes.

Perinatal and infant health outcomes are impacted by the social determinants of health - the conditions in which people are born, live, work, and age. Social determinants of health include factors like socioeconomic status, education, community environment, employment, social supports, and access to health services.[1] Inequities among one or more of these determinants can have significant impact on the health outcomes of individuals and entire communities. To effectively improve health outcomes, it is important to look at both disparities and social determinants of health to identify and address the root causes (i.e., racism, classism, sexism). To proactively address intersectional factors impacting racial and ethnic disparities, PICHC programs should incorporate a reproductive justice framework.

Reproductive justice is defined as the human right to maintain personal bodily autonomy, make

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1 Centers for Disease Control and Prevention. Social Determinants of Health. Available at: http://www.cdc.gov/socialdeterminants/definitions.html.

choices about having children (or not), and parent children in safe and sustainable communities.[2] Reproductive justice acknowledges that an individual cannot freely make choices about their pregnancy when options are limited by oppressive circumstances or lack of access to services. Reproductive justice aims to improve perinatal health by addressing the various intersectional issues that can impact an individual's fertility and/or reproductive decision making, including but not limited to: access to contraception, comprehensive sex education, prevention and care for sexually transmitted infections, alternative birth options, adequate prenatal and pregnancy care, domestic and sexual violence assistance, adequate wages to support families, and safe homes.

Working within a reproductive justice framework, this funding opportunity seeks to address the impact of social determinants of health, and achieve health equity and systems-level change(s) through community collaborations, to mobilize a community response and engage diverse partners, including community residents.

Medicaid funding is a key source of support for the PICHC initiative, and PICHC activities will primarily focus on Medicaid-eligible individuals and populations. Improving perinatal health is a key priority within the NYSDOH Prevention Agenda, Title V Maternal and Child Health Services Block Grant (MCHSBG), Maternal, Infant and Early Childhood Home Visiting (MIECHV) initiative, and the state Medicaid program.

A note on gender-based language:

The Division of Family Health recognizes and supports the experiences of gender- and sexual-minority New Yorkers, including those who are pregnant and parenting, and their families. As such, the title of this initiative has been changed accordingly; from the previous "Maternal and Infant Community Health Collaboratives (MICHC)" to Perinatal and Infant Community Health Collaboratives (PICHC). Wherever possible and applicable, this document uses gender-neutral language (i.e., "person", "individual", "client") instead of gender terms such as "woman" and "female". Data provided may be based on binary gender variables (male/female) as data for gender- and sexual-minority populations may not be available. Likewise, names of federal programs, agencies, etc., that use gender-based language cannot be changed. It is the expectation that funded applicants will serve all eligible pregnant, postpartum, and interconception individuals, and their families, regardless of race, culture, sexual orientation, biological sex, gender identity, and gender expression.

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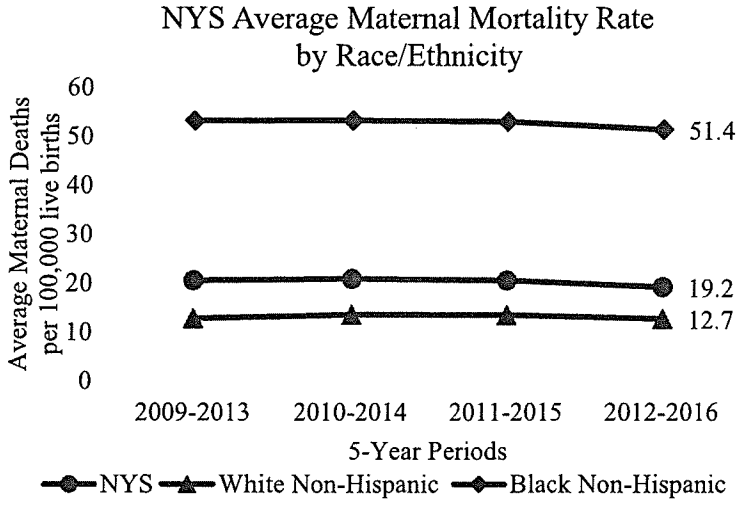
2 SisterSong, Inc.; https://www.sistersong.net/reproductive-justice (O'Mara-Eves, 2015)

Table 1: New York State Maternal Mortality



Key Population Metrics: NYS has made significant progress in improving the health of individuals and infants over the past decade, however disparities, especially among racial and ethnic minority populations continue to persist. Infant and maternal mortality rates are often used as indicators of a population's overall health. While the annual maternal mortality rate in NYS has declined 35% in recent years (from 26.0 deaths per 100,000 live births in 2008 to 16.8 deaths per 100,000 live births in 2016), the rate of maternal deaths for non-Hispanic black mothers remains close to four times the rate of maternal deaths for non-Hispanic white mothers. Reducing racial disparities in maternal mortality rates is a priority of both the 2020 NYS Title V Program, and the NYS Prevention Agenda.

Over the past two decades in NYS, both infant deaths and the infant death rate have steadily declined (from 1,728 infant deaths in 1997 to 1,026 infant deaths in 2017; from 6.7 infant deaths per 1,000 live births in 1997 to 4.5 infant deaths per 1,000 live births in 2017). Despite NYS' successes in reducing overall infant mortality, significant racial disparities persist. While the infant mortality rate is at a low of 4.5 deaths per 1,000 live births, black infants have twice the likelihood of death during the first year than white infants.

In April 2018, Governor Cuomo announced a comprehensive initiative to address maternal mortality and reduce racial disparities in outcomes. As part of this initiative, the NYSDOH conducted a series of community listening sessions across the state to engage participants in a discussion of the barriers and issues which impacted their birth experiences (*Voice Your Vision - Share Your Birth Story*). Common barriers expressed included: lack of access to healthcare, lack of information from providers, the impact of racism on the quality of care received, lack of social supports prenatally and postpartum, and lack of community services and resources. The Governor's initiative included a Taskforce on Maternal Mortality and Disparate Racial Outcomes tasked with providing expert policy advice on improving maternal outcomes, addressing racial and economic disparities and reducing the frequency of maternal mortality and morbidity in NYS. In March 2019, the Taskforce issued ten recommendations to decrease maternal mortality and morbidity and reduce racial disparities in NYS (*Recommendations to the Governor to Reduce Maternal Mortality and Racial Disparities* - March 2019). Governor Cuomo remains committed to implementing the Taskforce recommendations, which includes expansion of CHW services in NYS. In January 2021, the expansion of CHW services was further recommended by the NYS Expert Panel on Postpartum Care as a means to incorporate their recommendation of providing "access to essential wraparound and care coordination services to all birthing people in New York State through 'Stress-Free Zones'" (NYS Expert Panel on Postpartum Care Final Report - January 2021).

Priority Communities:

Priority communities were identified based on a county-level analysis, using the following indicators

related to maternal and child health and well-being: preterm birth; low birth weight; infant mortality; maternal mortality; late or no prenatal care; poverty; and disparities of these indicators by race. Composite z-scores were calculated for the rates of the indicators and for the burden (cases) of indicators with equal weights. Counties with burden z-scores above a value of 0 (i.e., indicating higher overall burden relative to the statewide values for all risk factors combined) were identified as high priority. Using this methodology, this RFA designated counties into two tiers. **Tier 1 includes the 11 highest-priority counties: Bronx; Erie; Kings; Monroe; Nassau; New York; Onondaga; Queens; Richmond; Suffolk; and Westchester**. Tier 2 includes all remaining counties. Maximum award levels were set based on these Tiers, and the Medicaid birth population within NYS counties. (**Table 2**)

Table 2: Maximum Funding by County

		County	Maximum funding per County	Base Funding	Total Variance Funding	Maximum Awards per County
Tier 1	Kings	Kings	$1,660,000	$455,000	$750,000	2
	High	Bronx, New York, Queens	$830,000	$455,000	$375,000	1
	Med	Nassau, Erie, Monroe, Suffolk	$795,000	$440,000	$355,000	1
	Low	Onondaga, Richmond, Westchester	$620,000	$320,000	$300,000	1
Tier 2	High	Albany, Broome, Chautauqua, Dutchess, Jefferson, Niagara, Oneida, Orange, Oswego, Rensselaer, Rockland, Schenectady, Sullivan, Ulster	$440,000	$320,000	$120,000	1
	Low	Remaining counties	$255,000			1

II. Who May Apply

A. Minimum Eligibility Requirements

*Please note: Applications **must** meet all the following minimum eligibility requirements to be accepted:

Applications will be accepted from Not-for-Profit 501(c)(3) organizations including, but not limited to: community-based health and human service agencies; Article 28 healthcare facilities; and local government entities, such as city and county health departments;
Applicants **must** propose to serve an area with a minimum of 200 Medicaid births (**Attachment 1**);
Applicants **must** propose to serve one Tier 1 county, **or** a single or multiple Tier 2 county(ies);
Applicants **must** be prequalified in the NYS Grants Gateway, if not exempt, on the date applications are due.